Frequently Asked Questions Related to the CARE Act Data Report

GENERAL QUESTIONS	
Questions	**Answers**
1. When is the submission deadline for the CARE Act Data Report (CADR) 2004 reporting period?	The submission deadline of the CADR for all CARE Act Titles is March 15, 2005. All reports received via the Web must be received by 12:00 midnight on March 15. All reports submitted by mail must be postmarked no later than March 15.
2. Where do I send my completed CADR?	Providers: All paper CADR submissions must be sent to your grantee of record for approval. Grantees: All paper CADR submissions should be mailed to HRSA's data contractor: WRMA/CSR Ryan White Project Attn: Ryan White CARE Act Data 2107 Wilson Blvd, Suite 1000 Arlington, VA 22201
3. What is the difference between a grantee and a provider?	A grantee is an agency that receives Ryan White funds directly from HRSA. A provider is an agency that receives Ryan White funds from another agency.
4. Do program and agency mean the same thing or are they different?	For the purpose of the CADR, they mean the same thing.
5. What is the URL for accessing the CARE Act Web Data Entry System?	The URL for accessing the CARE Act Web Data Entry System is https://performance.hrsa.gov/hab. You will need your assigned registration code noted on the cover letter received with your CARE Act Data Report and instructions package. First, click on the "Registration Screen" link to create a User Name and Password. Once you have registered you may log in to view and begin entering your CADR.
6. Is there a minimum browser requirement to access the Web Data Entry System?	Yes. You must have Internet Explorer version 5.5 or higher. Netscape is not supported.
7. Where can I download the CARE Act Data Report and instructions?	The CADR and its instructions are furnished as PDF files and can be downloaded at http://www.hab.hrsa.gov/tools. You must have Adobe Acrobat Reader software, which can be downloaded by clicking on the Adobe PDF icon in the center left side of the screen.
8. Some consortia utilize numerous small providers for special service activities. Should each of these small providers complete a CADR?	The consortia should continue to report as they have in the past.
9. How should Title IV providers and grantees complete the CADR?	Continue to report as you have in the past. If the grantee has a centralized system for collecting data, then the grantee should complete one report and submit it to HAB's data contractor or via the Web. If no centralized data collection system exists, each service provider (reporting entity) should complete an individual CADR for the services it provided and submit the form to its grantee who then completes a cover page and submits all the provider reports together to the data contractor.

10. Is it acceptable to submit some provider CADRs on the Web and some on paper?	It is acceptable to submit some provider CADRs on the Web and some on paper.
11. Should Title IV Adolescent Initiative programs report using the CADR?	Title IV Adolescent Initiative programs should submit a SEPARATE CADR containing all of its Adolescent Initiative program data, even if funded under other CARE Act Titles. If funded by additional CARE Act Titles, the Title IV Adolescent Initiative program should submit one CADR containing all of its Adolescent Initiative program data and a second CADR containing the data from the other Titles under which it is funded. This is the only instance in which two forms may be completed.
12. In some instances, a provider may serve clients who fall under several different grantees funded through different CARE Act Title programs. For example, one provider in Northern VA may see clients funded under the VA Title II program and the DC Title I EMA. This same provider must report its data to the state of VA and to the DC EMA. Would this provider complete two CADRs for VA and DC, specifying its data for Title II versus Title I clients respectively?	Each provider should complete the entire CADR for all clients served during the reporting period and send copies to each grantee it contracts with, even if some of the information included on the provider's CADR is not relevant to a particular grantee. The CADR only allows for Title-specific information in Section 6. If a grantee requires more title-specific information, it should request it separately from its providers.
13. What is an EIN?	EIN stands for Employer Identification Number. This is often the same as your agency's Taxpayer ID number.
14. If two different programs have the same tax ID# but receive funding under different Titles, do they have to complete a single CADR?	No, each program would complete its own CADR and submit the CADR to the grantee-of-record. For example, in Florida, all the local health departments have the same tax ID#, but each health department would complete its own CADR and submit it to the Florida Department of Public Health (the Title II grantee). If any of the local health departments are also funded under Title I, III or IV, they would also send a copy of the CADR to the grantee for that Title.
15. Does an agency need to fill out a separate CADR in order to include its ADAP information?	No. An agency's ADAP information should be included within its CADR.
16. Does a provider who does not provide direct services need to fill out a CADR?	Yes. All agencies receiving CARE Act Funding should complete a CADR. Agencies who only provide indirect services should complete Items 1-11 of the CADR.
17. Will there be a penalty for a large number of unknowns reported for specific items on the CADR?	Grantees are expected to work with their service providers to establish procedures for collecting all information on the CADR for all clients served during the reporting period. Project officers within the individual Title programs will be notified when grantees report large numbers of unknowns or omit data. HAB will decide how to handle such deficiencies.
18. To count an affected individual as a client, does the infected family member or partner need to be a client of the agency?	Yes, in order to consider this individual as a client who receives CARE Act services, the individual must be linked to a client with HIV infection who received services from your agency during the reporting period.
19. Does the CADR take care of CBC/MAI (Congressional Black Caucus/Minority AIDS Initiative) requirements?	Services provided to clients using CBC/MAI funding must be reported on the CADR, as would any other services. However, grantees are still responsible for reporting CBC/MAI information to HAB separately. Grantees should

	include their CBC/MAI funds in their total funding amount.
20. Will grantees be provided with electronic copies of their data reports?	Yes. Following the data verification process, each grantee will receive an email containing all of their CARE Act data.
21. How can I obtain the Ryan White Care Act Annual Data Summary?	Summary reports are normally posted on the HRSA Web site shortly after they're produced. You can also request one through your HAB Project Officer.
22. Can updated information be submitted after the original CADR has been submitted?	Yes, updated information may be submitted prior to the submission deadline. If submitting on paper, include a note stating that this most recent version should be accepted as the final version. If submitting via the Web, contact Data Support for assistance.

COVER PAGE

Questions	Answers
1. If submitting a complete CADR report via the Web, does the grantee need to send the signed cover page to HAB's data contractor separately?	Yes. The signed cover page must be mailed or faxed to: WRMA/CSR Ryan White Project Attn: Ryan White CARE Act Data 2107 Wilson Blvd, Suite 1000 Arlington, VA 22201 (703) 312-5230 (fax)
2. Who signs the cover page?	The individual responsible for quality assurance at your program or agency should sign the cover page.
3. Can the cover page be submitted via fax?	Yes, the cover page will be accepted via fax.

SECTION 1: SERVICE PROVIDER INFORMATION

Questions	Answers
1. Should grantees with several subcontractors combine all of the data?	Aggregation is allowed, but is not encouraged if subcontractors are providing services under several Titles and will be completing their own CADRs.
2. **Item 3:** Where contact information is requested on the CADR, is HAB looking for the primary service provider contact or a data contact?	HAB would like contact information for the person responsible for the provider's data. This would also be the same person who HAB's data contractor should contact to resolve any data issues.
3. **Item 5:** I only capture client information every six months, and the six-month period does not fall at the end of the reporting period. Am I required to ask for the information again?	Grantees/providers should report the most recent information they have for each client. They are not required to ask these questions of clients again at the end of the reporting period. Grantees/providers can follow their own schedule for collecting this information.

4. Item 6: How do I determine whether to use reporting scope "01" or "02"?	HAB's preference is that all grantees report on all clients who received services eligible for CARE Act funding (reporting scope "01") during the reporting period; however, grantees may contact their project officer at HAB for permission to report using the funded reporting scope ("02"). **Grantees who want to do this must be able to track clients and services by funding stream**. Service providers should contact their grantee to determine which reporting scope the grantee would like its service providers to use. Under the funded reporting scope ("02"), only those clients who receive a CARE Act-funded service are reported. Under the eligible reporting scope ("01"), all clients who receive a service eligible for CARE Act funding are reported, even if that service was not paid for with CARE Act funds. Often CARE Act funds are blended with other grants and reimbursement funds and the provision of individual service units cannot be identified by distinct funding streams within provider organizations. The eligible reporting scope ("01") thus allows for a wider spectrum of data collection related to CARE Act services. **Grantees need to make sure all of their providers use the same reporting scope.**
5. Item 6: With regard to the reporting scope "01," which services are eligible for Ryan White funding?	Services eligible for CARE Act funding are listed in Section 3, Item 35 on the CADR. Under reporting scope "01," grantees and service providers are responsible for reporting on all clients receiving services eligible for CARE Act funding.
6. Item 10: Should SPNS (Special Projects of National Significance), AETC (AIDS Education and Training Centers), or DRP (Dental Reimbursement Program) funding be reported in Item #10?	No, these funding sources should not be reported in Item 10. Services provided using SPNS funding should **only be reported on the CADR if** they are also Ryan White eligible services **and** the agency reports using the eligible reporting scope ("01").
7. Item 11: How should a grantee complete this item?	If grantees do not contract out for support services, then they can report whatever services were provided in-house. This question was designed to allow subcontractors who only provide support services to stop completing the form at this point.
8. Item 11: A Title I EMA subcontracts with an agency for technical assistance and quality management. How should this be reported?	The subcontractor completes a CADR through Item 11 only (checking off the two support services) and stops. The subcontractor then submits this CADR to the Title I EMA.
9. Item 15: If a grantee is encouraged to target incarcerated individuals by the state but does not receive money specifically for this, does it still report in Item 15 that it targets incarcerated individuals?	Yes. Grantees should report all populations targeted even if they do not receive or allocate money specifically for this purpose.
10. Items 19-22: In the "funding received section," should the amount awarded or received be reported?	Report only the amount actually received during the reporting period.
11. Items 19-22: Should providers subtract unexpended funds from the funding reported on the CADR?	No. Providers should report on all funding received whether expended or not during the reporting period.

12. Items 19-22: Should grantees include the funds they distributed to their providers in the total amount of funding they received?	Yes. All funding received should be included regardless of whether the funds were used strictly by your agency or distributed to providers.
13. Items 19-22: A grantee did not annualize their data in the past but instead reported fiscal year data. Is this still permissible for the CADR?	No. Grantees should annualize their fiscal data, even if project officers have given the grantee permission in the past to report fiscal year data rather than annualized data. *Refer to the instructions for specific information on how to annualize funding data.
14. Item 23: Does "funds expended on oral health care" apply only to Dental Reimbursement Program (DRP) participants?	No. This does not apply to DRP participants. The DRP does not use the CADR for annual reporting. Only Title I, II, III, and IV grantees and their service providers should report on this item for all clients who received oral health care during the reporting period. For this item, grantees should **report only the amount of CARE Act Funds** that were expended on oral health, regardless of the funding scope they choose in Item 6.

SECTION 2: CLIENT INFORMATION	
Questions	**Answers**
1. Item 24: How does a provider report a client who is initially diagnosed as HIV positive, but is later shown—through subsequent testing results—to be HIV negative?	The provider should report whatever the diagnosis is at the end of the reporting period.
2. Item 24: How are HIV-exposed infants categorized on the CADR?	If their status is known (HIV-positive or negative), then it should be reported on the appropriate line. If their HIV status is unknown, then it should be reported as such.
3. Item 24: How can a provider report someone whose HIV status is unknown under the CARE Act?	The person should be reported as HIV status unknown/unreported (affected). In 26-34 these clients should be combined with HIV-negative (affected) clients and reported in the affected columns.
4. Item 24: How should a provider report a client who was previously HIV negative and receiving services, but was re-tested in the current reporting year and found to be HIV positive?	If the client was reported as an affected individual in the past, then they would be reported as an "active client, continuing in the program." However, if the client was never reported on in previous years, the client should be reported as "New." The client would also be reported as HIV positive in the appropriate sections.
5. Item 24: Who is included under the HIV negative category?	Only "affected" clients who are HIV negative, or clients whose HIV status is unknown, fall under the HIV negative category. To be considered affected, a client must be either a family member, spouse, or partner who has been "affected" by a client's HIV-positive status. See the glossary in the CADR instructions for more information.
6. Item 24: Should the total in Item 24 be equal to Section 6.2 totals?	These totals should be equal only if the agency is **only** funded under Title IV.
7. Item 25: If a client is discharged and then later re-enters the program, should the individual be counted as a new client?	The client who returns for care after an extended absence should not be considered new unless past records of their care are not available.
8. Items 26-33: What is the correct way to report clients who died during the reporting period?	Deceased clients should be reported under the category in which they were last reported before their death.

9. Item 26: Is there a standard breakdown for gender?	The classifications currently used in gender question #26 represent the HAB standard for annual reporting of gender.
10. Item 27: Why are the age categories not standardized across HRSA and CDC?	HAB staff has worked with CDC staff to standardize age categories to the extent possible. The age categories in the CADR correspond to the HRSA categories; other CDC programs may vary in their use of age categories.
11. Items 28-29: Is the way that the ethnicity/race questions are asked on the CADR the standard for all agencies receiving Federal funding?	Yes, all agencies receiving Federal funding must comply with the Office of Management and Budget (OMB) standards for capturing and reporting race and ethnicity.
12. Item 29: How should providers report clients who do not self-report a race? (e.g. a client reports that they are Hispanic and does not choose a race)	All clients should be asked the ethnicity and race questions on the CADR. If a client does not identify an ethnicity or race, then the client should be reported in the unknown/unreported category.
13. Item 30: Who is included in a household?	A household can be made up of family members, a spouse, partner, or non-family members that reside together. The income of all individuals (over the age of 15) that occupy a single residence should be included in the household income reported in Item 30, unless an individual does not directly contribute toward the daily living expenses of the other people within the residence (e.g. someone who rents a room in a house and pays his/her own bills and living expenses separate from the other people that occupy that house).
14. Item 30: Household income - clients who are HIV positive and affected are listed in two separate columns, but some households include both HIV positive and affected clients. How should this be reported?	The total household income for each client receiving services would be the income of all HIV positive and affected clients living in the household. Each client would be reported separately but if s/he resides in the same household, the same income information would be entered for each client.
15. Item 30: How should providers categorize the household income of clients who are homeless?	In Item 30, homeless clients should be reported in their income category (which will constitute their household income). If the clients report that they have no income, they should be counted in the "Equal to or below the Federal poverty line" category or the "Unknown/unreported" category, depending on the response of the client.
16. Item 31: How should providers categorize the housing/living arrangements of clients who are homeless?	The instructions for Item 31 include homeless clients in the definitions for the "non-permanently housed" category.
17. Item 32: How do providers report a client with more than one type of medical insurance?	The primary insurance, or the one that reimburses the most, should be reported. The list of insurance types in Item 32 is not hierarchical.
18. Item 32: How do providers report clients whose only source of medical insurance is Title III funds?	These clients should be reported in the 'no insurance' category.
19. Item 32: If a grantee pays private insurance premiums for clients, under which insurance category should these clients be reported?	Classify these clients as being publicly insured. If you're administering a HIP, these clients should also be included in Section 8.
20. Item 34: What is the definition of inactive?	Each individual grantee/provider determines the period of time that must pass before a client is considered inactive.

SECTION 3: SERVICE INFORMATION	
Questions	**Answers**
1. Item 35: Some Title IV funded agencies provide services to exposed infants whose HIV status is not yet known. Since the CADR does not have categories specific to exposed clients, how are these services reported on the CADR?	For 2004, report these clients as HIV affected. Title IV grantees will receive with their annual CADR mailing a revision to Section III, Item 35 that will allow affected client and visit counts to be reported in rows a-i. Online filers will also be able to report services to exposed infants if and only if Title IV funding is indicated in Section 1 of the CADR.
2. Item 35: Can Ryan White CARE Act funds be used to provide services to prisoners?	Please see ***HAB Policy Notice 01-01: Use of Ryan White CARE Act Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons.*** Visit the HAB Web site at http://hab.hrsa.gov/tools/adap/ for more information. Providers should only use CARE Act funds to provide discharge-planning services to prisoners (case management, etc.).
3. Item 35: Should grantees and service providers report on fee-for-service treatments or services on the CADR?	Providers should track all services that they pay for.
4. Item 35: What is the rationale for not recording visits for services k.–af.?	To reduce burden, a decision was made to ask this information for only critical, health care-related services.
5. Item 35: What constitutes a visit?	“Visit” should be defined by your program. However, a client may only have one visit for each service category per day. For a residential substance abuse treatment center, each day in a residential facility equals one visit. For example, if a client spends 20 days in a residential facility, this counts as 20 visits.
6. Item 35a/35aa: An agency reimburses for medical services but does not actually provide the medical services. Where should this be reported in Item 35?	If Care Act funds are used to pay for the services, then these services should be reported in 35a (Ambulatory/outpatient medical care) and medical information should be collected on all clients reported in 35a. If medical information cannot be obtained for these clients, then the services should be reported in 35aa, Referral for health care/supportive services.** ** This is not the preferred method of reporting. Providers should make every effort to obtain medical information on clients whose medical services are paid for by the provider using CARE Act funds.
7. Item 35b/35aa: A clinic/provider has two psychologists who provide services to clients. One psychologist is within the HIV care program and receives CARE Act funds and the other is not in the HIV care program and does not receive any CARE Act funds. How should clients that receive services from these psychologists be reported in the service information table?	Clients who receive services from the psychologist funded by CARE Act monies should be reported in 35b, Mental health services. If the provider chose the eligible reporting scope (“01”) in Item 6, clients who receive services from the psychologist not funded by CARE Act monies should be reported in 35aa, Referral for health care/supportive services. However, if the provider chose the funded reporting scope (“02”) in Item 6, services provided by the psychologist who does not receive CARE Act funds would not be reported on the CADR.
8. Item 35j: Under which service category should providers report face-to-face case management?	Face-to-face case management or any other type of case management contact (i.e., telephone or email) should be counted under case management as one visit.

9. Item 35j and 35n: Should funds for client advocacy (e.g. case manager) be reported under case management or client advocacy?	If at the time of the case management visit, client advocacy services were provided, it is okay to report under both.
10. Item 35l: Under which service category should providers report child respite care?	Child respite care falls under "Child care services." However, this category does not include child care for working parents; it only includes child care when parents need someone to watch children while they are receiving services.
11. Item 35r: Under which service category should a provider report groceries, food vouchers, and food stamps?	Report these services in Item 35 under "Emergency Financial Assistance."
12. Item 35u: Are rental subsidies included in the definition for housing services in 35u?	No. CARE Act funds should not be used to provide clients with assistance in paying their rent. This type of service falls under HUD.
13. Item 35x: Should providers be discouraged from using unknown/unreported for outreach services?	Yes, this category should **NOT** be used for reporting any anonymous clients. If grantees or service providers conduct outreach activities in large settings such as health fairs, individuals reached should not be included on the CADR, unless they are accounted for in Section 2 with demographic information.
14. Item 35z: How should a provider document mental health services for an affected client?	These individuals should be reported under "Psychosocial support services."
15. Item 35aa: If Title III grantees or providers only provide substance abuse referrals, do they need to track services provided through referrals in order to have numbers to report in Items 35d and 35e?	For reporting purposes, Title III grantees and service providers would report these clients in Items 35aa and 63. The Title III program requires grantees to be able to track this information to see if the client received the service.
16. Item 35aa: Does a referral fee have to have been paid in order for the referral to be counted?	No, providers do not have to pay referral fees in order for a referral to be counted in Item 35aa.
17. Item 35aa: How is "referral" defined by HAB?	The definition of a referral is listed in the glossary section of the CADR instructions. It states that a referral for health care/supportive services is: "The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program."
18. Item 35aa: Do labs have to be reported under the referral category if clients are sent to another location to get labs?	No, labs are covered in a medical service visit. If a client goes to a doctor for a medical visit and is also sent to get labs, it should be counted as one visit, rather than two visits or a medical visit and a referral.
19. Item 35ae: Should case managers report adherence treatment services under case management or adherence?	If at the time of the case management visit, treatment adherence services were provided, it is appropriate to report under both.

SECTION 4: HIV COUNSELING AND TESTING (*C* &T)

Questions	Answers
1. Which service providers should complete this section?	Providers funded under any and all Titles should complete this section. C&T is a requirement for Title III and IV grantees and is now funded as components of Early Intervention Services for Title I and II grantees.
2. Should grantees report on all clients who received HIV counseling and testing (C&T) during the report period or only on those clients who received C&T funded by CARE Act funds?	Grantees/providers who selected the eligible reporting scope ("01") and who provided C&T during the reporting period, must complete all items in Section 4 on all individuals who received C&T, regardless of who paid for the testing. Grantees/providers who selected the funded scope ("02"), and used CARE Act funds to pay for the service must complete Section 4 for only those clients who received C&T as a CARE Act-funded service. Those who selected funded reporting scope ("02") and provided C&T, but did not use CARE Act funds for these services, can answer "yes" to Item 36, "no" to Item 37, skip Items 38–44, and continue with Section 5 of the report.
3. Can Title I agencies use CARE Act funds for HIV counseling and testing?	Yes, if C&T is provided as a component of the early intervention services for Title I and II. For C&T to be considered part of early intervention services, agencies must also provide at least one other early intervention service. Title I and II early intervention services include outreach, counseling and testing, referral and the provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local continuum of care.
4. Under HIV counseling and testing, if someone tests negative, should s/he be reported on the CADR?	These individuals are accounted for in Items 38–41 on the CADR. However there is no place to specify the number of individuals who test negative.
5. We subcontract outreach workers whose only role is to conduct counseling and testing. Any adolescents they come across are referred back to us. How do we capture, but not duplicate, these data?	The subcontractor should complete Section 4, and you should include their data in your CADR. If the subcontractor is funded under multiple titles of the CARE Act, they should fill out an entire CADR (in which case you would exclude their data on your report).
6. **Item 36b:** Where should infants who are tested for HIV, but whose mothers are not clients, be reported?	Infants who are tested for HIV should be reported in Section 4, Item 36b, but should be excluded from the remaining items in the section.
7. **Items 38-42:** How can anonymous clients be entered into CAREWare?	Anonymous clients cannot be entered into CAREWare, however during the CAREWare CADR upload process you are able to enter Section 4 information.

SECTION 5: MEDICAL INFORMATION

Questions	Answers
1. How should infants be reported in Section 5?	If the infants are confirmed to be HIV positive, then they should be reported in Section 5. If their HIV status is still unknown or indeterminate, then they should not be reported in this section.
2. What is the definition of Medical Service Provider?	A Medical Service Provider is any service provider who provided ambulatory/outpatient medical care (Item 35, service category "a").

3. If clients are referred to individual physicians who are given some CARE Act funds, should these clients be reported in Section 5?	Yes. If the physicians receive CARE Act funds, then the clients they serve need to be reported in Section 5.
4. Item 46: Can providers report percentages for Item 46?	No. Providers must report actual numbers for Item 46.
5. Item 46: If providers know the exposure categories for their clients but do not have access to the rest of the information in Section 5, should they fill in the exposure data?	Providers should report all medical information available to them. However, they should make every effort to obtain all the medical information included in Section 5.
6. Item 47: What is the definition of "treatment" in Item 47? Does it mean prescribed, in progress, or completed?	In Item 47, "treatment" refers to treatment that has been initiated, which can include a physician writing a prescription for medication. Note that the physician may not have information regarding the patient's filling the prescription or taking the medication.
7. Item 47: Are clients only counted if the TB skin test is planted and read?	Item 47 refers to TB test planted.
8. Items 47-52: Is client self-report acceptable for Items 47–52?	No.
9. Item 49: What are the criteria for including a client in Item 49 (antiretroviral therapies) at the end of the reporting period?	Any client who is on any type of antiretroviral therapy at the end of the reporting should be included in Item 49.
10. Item 49: If a client receives both dual and triple combination therapy (HAART) in one reporting year, how should they be reported on the CADR?	Count the client under the therapy they were receiving at the end of the reporting year.
11. Items 51-55: How is a woman who is pregnant for a few weeks in one reporting period and then delivers in the next reporting period reported in Items 51–55?	In this situation the woman would be reported in Items 51 and 53 for both reporting years. The child she delivers would only be reported under Items 54 and 55 during the second reporting year (since that was when the child was delivered).
12. Item 53: Is this item meant to track women who are prescribed antiretroviral medications or women who actually take their antiretroviral medications?	All women who are *prescribed* antiretroviral medications should be reported in this item regardless of whether or not they actually take the medications.

SECTION 6: DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV

Questions	Answers
1. When a multiply funded provider completes the Title IV information in Section 6.2, should the provider only report those served under Title IV programs?	The information reported in Section 6.2 should only include those served under Title IV programs.
2. A Title IV grantee is also a Title II provider. How does this grantee report a 60-year-old male receiving case management services under Title II?	Report this client in other relevant sections of the CADR (i.e., Section 2 and 3); however, do not report him in Section 6.2.
3. Items 58 and 59: Under which response category should a provider report children who were exposed to HIV by sexual abuse?	Report these children under the "other" exposure category in the tables in Items 58, 59 and 68.

4. Item 63: If a Title III agency refers clients to a clinic within the umbrella organization, but that clinic is not funded by CARE Act money, is the referral considered outside the EIS?	A referral is considered outside the EIS if the clinic (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Title III grantee or its parent organization.
5. Item 63: If a Title III agency refers clients to a clinic considered outside the EIS, how are the services reported?	Indicate that the service was provided through referral in Item 63, and list the services in Item 35 (Section 3) as referrals.

SECTIONS 7 AND 8: APA/ADAP AND HIP INFORMATION

Questions	Answers
1. How should a provider report ADAP funds used to pay for clients' health insurance?	Report on all clients who received this service in Section 7 (APA/ADAP Information). If you also complete Section 8: HIP Information, you should report the ADAP funding used in Item 9.
2. A Health Insurance Continuation Program (not directly CARE Act funded) is conducted under ADAP. Which sections of the CADR should be completed in order to capture the data from this program?	If ADAP funds were used to pay for health insurance, then complete the ADAP section but not the HIP section.
3. Under Title III, should emergency pharmaceutical assistance (340-B) be reported under Section 7?	No. For reporting purposes, Title III grantees should report this under Emergency Financial Assistance (Section 3, Item 35r). However, for programmatic information it falls under primary medical care. Note that there is a distinction between administering a **formal** pharmaceutical program (offering <u>ongoing</u> assistance) and providing emergency funding. Several grantees/consortia have developed local APAs. If money is allocated for prescriptions on an ongoing basis, that information should be reported in Section 7.
4. In Sections 7 and 8, does "new client" refer to clients who are new to the program or new to the agency?	"New clients" refers to clients who are new to the program, not clients that are new to the agency. Any client who receives their first service in the APA or HIP program during the reporting year should be reported as a new client in either Section 7 or 8. Clients that were seen in previous years at the agency but became a part of the APA program or HIP for the first time during the reporting year should be reported as new clients in Section 7 or 8.
5. Is funding reporting in Section 7 and 8 meant to be total Title funding or only APA and HIP funding?	In Sections 7 and 8 only funding used for APA programs and HIPs should be reported.
6. Where can I find ADAP drug codes?	CARE Act Data Support maintains a list of all drug codes. A list of the most frequently used HIV drugs and their corresponding codes can be found on the TA Web site at http://www.careactdatasupport.hrsa.gov/Resources.htm.